California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
April 20, 2007

The meeting was called to order by Vito Genna, Chair, at approximately 10:00 a.m., at the Sterling Hotel in Sacramento, California. A quorum of half of the members plus one was in attendance.

Present:

Vito J. Genna, Chairperson
William Brien, MD
Marjorie Fine, MD
Howard L. Harris, PhD
Adama Iwu
Corinne Sanchez, Esq.
Josh Valdez, DBA
Sol Lizerbram
Corinne Sanchez, Esq.
Sonia Moseley

Absent:

Janet Greenfield, RN
Jerry Royer, MD, MBA
Kenneth M. Tiratira, MPA

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Terrence Nolan, Office Manager

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Elizabeth Wied, Chief Counsel; Beth Herse, Legal Counsel; Joseph Parker, PhD, Health Quality and Analysis Division; Jonathan Teague, Manager, Healthcare Information Resources Center; Mary Tran, PhD, MPH, Administrative Data Programs; John Kriege, Data Asset Manager; Brian Paciotti, PhD; Mallika Rajapaksa, PhD; Niya Fong

Also Present: Jamila D. Davidson, MD; Darryl B. Nixon, California Association of Health Facilities

Approval of Minutes: A motion was made, seconded and carried to approve the minutes of the February 23, 2007 meeting.

Oath of Office: David M. Carlisle, MD, PhD, Director, OSHPD

Dr. Carlisle administered the oath of office to newly appointed Commissioner, Sonia Moseley. Ms. Moseley has been a registered nurse since 1960. She received her Nursing degree in St. Louis, Missouri and moved to California in 1964. She trained at Kaiser Permanente and became one of the first adult medicine practitioners.

Ms. Moseley held the office of Executive Vice-President for the United Nurses Associations of California. She resigned this position in December of 2006. In March 2007 she was elected Vice-President for Nursing for the International Union of Hospital and Healthcare Employees.

Chairperson's Report: Vito Genna, Chair

For the benefit of the new Commissioner's, Chairperson Genna summarized the committees.

The Appeals Committee handles appeals from healthcare providers that have not submitted their information by the current deadline and have incurred a one hundred dollar a day fine. The Appeals Committee has not met recently and Chairperson Genna cited this as a positive indication of how well the Department is working with the healthcare providers. The Appeals Committee is currently Chaired by Corinne Sanchez, Esq.

The Health Data and Public Information Committee, HDPIC, balances the need for data, the cost factor for hospitals, and the information consumers need. The HDPIC is currently Chaired by Howard Harris, PhD.

The Technical Advisory Committee, TAC, works on risk-adjusted outcome studies. Statutory requirements dictate the composition of the Committee insuring that providers, consumers and researchers are represented. The Technical Advisory Committee is currently Chaired by Jerry Royer, MD.

Acting Executive Director's Report: Kathleen Maestas

Ms. Maestas attended the recent California Health Policy Forum on the transformation of public health and the role of the new Public Health Department. The panel was comprised of Jerry Wasserman, Senior Health Policy Researcher from Rand; Bobbie Berkowitz, Professor and Director for the Center of Advancement from the University of Washington; Dr. Leslie Beitsch, from Florida State; Dick Jackson, Professor of Environmental Health of the City Regional Planning for UC Berkeley; and Poki Namkung, Public Health Officer of Santa Cruz County and President of the National Association of County. The panel was invited to make recommendations in the areas of infrastructure, data, and financing, to the Director of the new Department, Dr. Mark Horton.

The Panel called for better coordination between the State and local level healthcare departments. The recommendation was made that the new Public Health Department be excused from some of current personnel and salary structure that is in place for State departments. Several members recommended that it would be valuable to develop quality measures similar to those measures used for hospital quality assessment that

would apply to public health. Panel members also agreed that global climate change is the preeminent public health issue of the future.

Panel member Poki Namkung, gave kudos to OSHPD in the area of data collection. Ms. Namkung stressed that the future in Healthcare will be data driven and especially data that is at the sub-county level. Ms. Namkung added that to make the data useful to healthcare consumers it must be reported at the local level, so people can relate to the information provided.

Dr. Carlisle added that Dr. Mark Horton is familiar with OSHPD's role in data acquisition, provision and analysis and that he anticipates a close relationship between the new Public Health Department and the Office.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

Dr. Carlisle announced that at last week's Assembly budget hearing virtually everything that OSHPD had presented was approved.

The Office will be relocating in two phases. The first phase will involve all divisions except the Facilities Development Division and Cal-Mortgage. The Office will be relocating to the Consumer Affairs building at 3rd and R Streets in Sacramento. The building is five blocks from the present location at the Bateson building. Once the second phase is complete which will involve relocating FDD and Cal-Mortgage, the Office will be the major occupant of the Consumer Affairs building.

Stephanie Clendenin is still the Interim Executive Director of Health Professions Foundation but Ms. Clendenin has also taken on the role of Acting Administration Division Deputy Director for the Office.

Legislative Update: David M. Carlisle, MD, PhD, Director, OSHPD

Currently four bills have attracted significant discussion from the Office.

AB520 is legislation that would require OSHPD to conduct a comprehensive study to identify the needs for hospital and health facility non-nurse and technical staffing. This follows the establishment of nurse to patient ratios for California hospitals and would also apply to non-nurse staffing.

AB371 does not specifically target OSHPD programs but touch on the Cal-Mortgage program as it requires that all general acute care hospitals that are applying for tax exempt bonds explain the allocation component that will go to injury prevention using zero lift technology for staffing.

SB139 is very significant legislation calling for the creation of a workforce clearing house with OSHPD's Workforce Division. This would make OSHPD the repository for all workforce information within the Agency, and the source of all policy information regarding healthcare workforce.

AB295 specifically impacts OSHPD's discharge data sets. This legislation recognizes that the Asian/Pacific Islander population in California is extremely diverse and calls for an expansion of the present 11 categories of Asian/Pacific Islander populations to 21. This would include categories such as Fijian and Malaysian which are currently not collected but are significant population groups in the State.

Presentation on Governor's Healthcare Reform Proposal: David M. Carlisle, MD, PhD, Director, OSHPD

6.5 million Californians are without health insurance. These numbers are derived from our California Health Interview Survey, which collects data specifically on California. 20 percent of the population under 65 is uninsured and most of the uninsured are in employed households.

In addition to addressing the uninsured, the Governor also is focused on the severe Medi-Cal under funding in California. The Governor does not feel that providers are being reimbursed fairly in the Medi-Cal program.

There also exists at present what the Governor terms a "Hidden Tax." $1,186 per family or $455 per person is the price that every person in California is paying to support the uninsuredness issue in the State. This type of cost shifting affects everyone.

The Governor's Healthcare Reform Proposal contains solutions to these issues. The Governor's vision is that Californians will stay well through prevention, will have access to affordable care and will have secure health insurance coverage.

The goals of the Proposal are reducing the "Hidden Tax," lowering overall healthcare costs and improving the care that Californians receive. It is in this last component that the Commission plays a vital role in evaluation and oversight for the Office. The Office then uses that advice in identifying high and low quality care and clarifying the way the healthcare delivery system work.

There are four tenets to the Proposal: Prevention/Wellness; Shared Responsibility; Coverage for all; and Affordability.

The Prevention/Wellness tenet continues the Governor's ongoing focus on well being, athleticism, and overall quality of life. The Governor has identified obesity and diabetes as significant contributors to health outcomes in the State of California. If the prevalence of obesity and diabetes can be reduced, it will mark a major contribution to health status in the State.

Another target is reduction of medical errors which goes hand-in-hand with the Governor's focus on e-Prescribing. Written prescriptions are very difficult for pharmacist to read and hospital orders can be misunderstood. E-Prescribing and E-Orders are an opportunity to significantly reduce medical errors.

The Governor also wants to continue the focus on tobacco control. California has the most successful anti-tobacco campaign in the country. Anti-smoking efforts have

resulted in a huge reduction in tobacco consumption. But much more can be done in this area.

The Shared Responsibility tenet of the Governor's Proposal is comprised of five components. Shared responsibility separates the Governor's proposal from its predecessors in that it does not rely on one just one sector of the healthcare system. In tandem with shared responsibility is shared benefit.

Individuals will to be responsible for providing their own healthcare coverage. They can do so through their employers or by participation in federal programs, like MediCare, Medi-Cal or Healthy Families. Individuals will benefit from guaranteed issue. Currently Californians do not have guaranteed issue and can be excluded from coverage or charge high premiums because of preexisting conditions. Individuals will also benefit from the reduction of the "Hidden Tax."

Government will be responsible for providing access to affordable coverage and that providers will be fairly compensated through Medi-Cal reimbursement. Government will benefit from a healthier population, greater economic productivity and reduced healthcare cost inflation.

Health plans will be responsible for guaranteeing access to coverage. Under the Governor's Proposal health plans will be required to restrict administrative cost to no more than 15 percent of their premiums. Health plans will benefit from a significant expansion in membership that will occur when all people in the State enroll in healthcare insurance plans.

Employers will be responsible for either directly providing health insurance or paying into a State purchasing pool if they have more than 10 employees. Employers will benefit from reduced healthcare cost, greater employee stability and morale.

Healthcare providers will be responsible for contributing fiscally to the Healthcare Reform Proposal. There is a four percent fee for hospitals and two percent for physicians proposed. Providers will be expected to control administrative cost. Providers will benefit from significantly larger numbers of insured patients, significantly reduced burdens of debt collection and uncompensated care, and greatly increased Medi-Cal reimbursement rates.

The Coverage for All tenet incorporates proposals to expand employer based coverage, Healthy Families and Medi-Cal programs. As an example of how this will play out in the general population, single white males, without dependents or qualifying conditions, who are currently ineligible for Medi-Cal will qualify under the Governor's Proposal.

The Affordability tenet will be achieved by reducing the "Hidden Tax." Individuals, as well as businesses will be given tax incentives to use pre-tax dollars to purchase individual health insurance. Under the Governor's Proposal there will also be caps on administrative cost for health plans and hospitals.

The Governor proposed that California could receive about $3.5 billion directly from the Federal government by expanding the Medi-Cal program based on the rules of the existing program. Although this was challenged in an article by the L.A. Times, Health and Human Services Secretary Leavitt came to California and stated that the funds will be available as expected.

The many components of the Governor's Healthcare Reform Proposal from an individual mandate, to incremental reform and fair play, speak to the depth and elegance of the Proposal.

Commissioner Fine asked whose role it would be to enforce the regulatory announcement.

OSHPD data will be used to define what 85 percent of dollars directed to patient care at hospitals means. OSHPD has very little enforcement or regulatory role in the healthcare sector, except as it applies to data submissions. That is why OSHPD has the Appeal Committee for CHPDAC. The enforcement will probably be distributed throughout the various health and insurance departments of the State.

Commissioner Brien asked with regard to the four percent hospital tax on net revenue and the two percent physician tax on gross revenue whether those numbers were going to be capped.

There is not a cap being considered at this time, but this is a work in progress. The specifics of these fees have not been developed. As legislation is introduced, there will be more precise information.

Commissioner Fine asked if the multi-billion dollar industry and ancillary health services in the State in the form of acupuncture, herbal remedies, and cosmetic surgery were going to be looked at as forms of revenue for funding.

That has not been proposed at this time, but during the legislative process there could be additional sources of funding identified and specified in the bill.

Commissioner Moseley asked if the Governor was trying to work with the various groups that have submitted healthcare proposals to try to reach some agreement on one piece of legislation.

The Governor's Proposal is far more sweeping than most of the other proposals that have been presented. The Governor's administration is negotiating with the Legislature and there will undoubtedly be some inter-discussion as the process goes forward.

<u>Update on Healthcare Outcomes Center</u>: Joseph Parker, PhD

The 2003-2004 hospital and surgeon level report received approval from Agency and has been submitted for the Governor's approval. This report rates 120 hospitals and 302 surgeons and is based on 2003-2004 data. There is also a section that rates hospitals on just the 2004 data included in the report as a snapshot of the most recent data.

For the first time, the 2003-2004 report will include ratings on internal mammary artery usage, which is the preferred conduit for most people receiving heart bypass procedures based on the 2003-2004 data. Another first for the report will be the inclusion of a section that discusses the relationship between surgeon volume and risk-adjusted mortality rates.

The Agency for Healthcare Research and Quality is a national organization that has a federal mandate to produce reports on the quality of care in the United States. Some of their measures are applicable to OSHPD's patient discharge data. The AHRQ has 12 volume and utilization indicators, such as CAB PCI and Caesarean Section rates, based on 2004-2005, that are now on the OSHPD website. Trend analysis will be added to the website as a complement to the data provided.

OSHPD is looking at the validity of AHRQ's patient safety indicators, which are basically complication rates, including transfusion reaction, post-op respiratory failure, and Iathrogenic pneumothorax. OSHPD is seriously considering reporting these at the hospital level, but not as a traditional outcomes report. OSHPD had previously not considered doing this because AHRQ had not included information from the OSHPD patient discharge data pertaining to the condition present at admission. Condition present on admission is important for discriminating between complications resulting from care and acute conditions that a patient arrives with. The results can be very biased and unreliable if the two are not distinguished. AHRQ has started to include this information and analysis in their software updates.

A validation of the patient discharge data is currently underway. The reabstractions will focus on DNR and condition present at admission coding for umbrella conditions such as, heart attack, community-acquired pneumonia, stroke, and congestive heart failure. A separate part of the study will focus on the coding of trauma cases, specifically the place of occurrence, which benefits public health research about the place of occurrence of trauma and accidents.

The next AB 524 Technical Advisory Committee meeting, to be held in combination with the Health Data and Public Information Committee, will be dedicated to a discussion of adding additional clinical data to the patient discharge data. The focus will be adding lab values, potential vital signs, and possibly one additional patient identifier, geo-coded address.

The two major presenters at the meeting will be Dr. Pine and Dr. Bindman. Dr. Pine brings empirical findings from his work with Pennsylvania hospital data, and has used these data to illustrate what improvements were achieved by adding certain data elements to the risk models. Dr. Bindman, who produced a report on expanding OSHPD's administrative datasets, will go over his recommendations. These recommendations are actually based on a review of the clinical literature and focus groups that considered what clinical data would produce the largest return in terms of improving risk models, prediction, and improvement of validity of outcome studies.

Review of the Community Acquired Pneumonia Report methods: Modeling with and without the DNR variable: Mary Tran, PhD, MPH

At the last CHPDAC meeting Commissioner Royer requested more information on how DNR was used in the Community Acquired Pneumonia Report.

First CAP patients are selected out of the patient data, and a logistic regression model is run in which adjustments are made for other illnesses that the CAP patients had co-morbidities, age, and other risk factors. This model assigns a co-efficient for those risk factors. Then the co-efficients are applied to each patient's medical record, resulting in a probability of death per patient. Then for each hospital, a sum across all the patients' probabilities is taken to arrive at the expected number of deaths for that hospital.

The next step is comparing the actual (observed) number of deaths that occurred with the expected number. For example, if a hospital had 15 deaths and the expected number came out to be 20, the hospital performed better than expected.

Then the ratio of observed to expected deaths is calculated. This ratio is multiplied by the statewide rate, which is 12.29, to arrive at the risk-adjusted death rate for the hospital.

In the CAP report the model was run two times with the same group of patients. The first time the outcome is death within 30 days, adjusted for demographics, age, gender, co-morbidities, and prior discharges. Then the model is run again, with the same group of patients, and the same adjustments, but with the addition of the DNR status as another risk factor.

The reason DNR is included is because it is thought to be a proxy for other critical, clinical conditions that the patients have that are not currently being risk adjusted. Whether DNR should be included in future models requires fuller discussion by the Technical Advisory Committee. Recent publications and our own analyses suggest that DNR may also be related to other factors, such as the hospital practices, patient and physician perceptions of risk of death, and decision-making about which treatments will be given or withheld.

In the CAP Report hospitals were not rated better than expected unless they performed better in both models. Also, they were not rated worse than expected unless they performed worse on both models.

Profile of California patients, 2005: Comparison of Patients Using the Patient Discharge Data plus the New Emergency Department and Ambulatory Surgery Center Data: Mary Tran, PhD, MPH

"Patient Profiles, 2005" is a new report that OSHPD is considering. It is a descriptive report addressing patterns of healthcare utilization in California, and not an outcome report. The report makes use of the newly available (2005) outpatient data reported by emergency departments and ambulatory surgery centers. It compares patients receiving care in hospitals (inpatients) with patients receiving care in emergency departments and ambulatory surgery centers (outpatients) in terms of their demographic characteristics,

their diagnoses, geographic area, payer, and the timing of when they sought care (day and month).

The data sources will be the patient discharge data for inpatients, which include patients admitted from the ED to the hospital. The emergency department data will exclude patients that were admitted. Ambulatory surgery center data will include both licensed free-standing and hospital-associated facilities. Department of Finance demographic data will be used for population numbers. Data from ALIRTS, the reporting system for the utilization and financials maintained by OSHPD, will also be incorporated.

OSHPD has been collecting patient discharge data for many years and recently has begun collecting emergency department visit data and ambulatory surgery data. Looking at these data sources together will create an opportunity for synergy.

The concept behind this new report is to show a big picture by combining these various datasets and hopefully provide useful information for discussions about emerging issues for the healthcare system in California.

Emergency Room closure data: John Kriege, SISA

OSHPD has been collecting facility licensing information for 30 years. Initially this was done to support the reporting programs, as a way to see who should be submitting reports and what they should be reporting. Over the years the licensing data has come to be seen as a useful in it own right. Often OSHPD has requests for information such as how many emergency departments closed last year, or how many hospitals have closed in the last five years.

Recently, there was a request from Agency, Health and Human Services for ED closures going back to 1990 for certain counties. This prompted OSHPD to investigate what this information might look like if it was done statewide for California. Mike Byrne prepared a map showing the change in geographic availability of emergency departments, including a table that shows, over time, the number of emergency department that have opened and closed. This map shows that there has been a decrease in the number of emergency departments in California.

Chairperson Genna observed that taking a cursory look at the information presented in the map it says one thing, such as the recent closure of a hospital in Fresno, but it does not indicate that the new system opening will have about the same number of beds, and within a year there will be another 50 beds and a trauma center which includes a helipad.

John Kriege agreed with Chairperson Genna and stated that is why the Office wants to make this kind of data available so it can be turned over and analyzed.

Dr. Carlisle pointed out that if you look at total ER beds vs ERs, despite the predominance of closures, there has been a fair plateau of total ER beds in the State. According to the map presented, there is a real concentration of closures, verses opening, in urban areas. What happens at this point is you may lose access to an ER

that is in proximity to you, but while the number of beds in the county has not changed, you access has changed.

When looking at the hospitals that are closing in urban areas, even if other hospitals add more emergency room beds, the impact, as seen from the data presented earlier, is that a large number of uninsured and under-insured patients end up in the emergency room for their care. This ultimately drives more emergency rooms to close in the area, and more hospitals to give up their emergency room status or put them in financial straits. When larger hospitals close, community hospitals are adversely affected. There is a ripple effect that takes a long time to see the end result. Just adding ED beds does not solve the issues.

Adjournment: The meeting adjourned at 1:50 p.m.